



General Opinion of the Conseil du statut de la femme

in Regard to New Reproductive Technologies

Foreword

For the past three years, the Conseil du statut de la femme has been studying serious women's issues raised by new reproductive technologies. It has set up a committee of experts, prepared research papers and other publications, and produced audiovisual presentations.¹ It has also submitted opinions to the Québec government, notably concerning the right of artificially conceived children to know their origins, the prohibition of preconception contracts and the restrictions that should be placed on prenatal diagnosis. The *International Forum on New Reproductive Technologies* was the climax of the Conseil's sustained efforts, for it provided an opportunity for discussions among experts from around the world and for broader public debate on the subject. Since that event, the debate has been fueled by women's groups and others troubled by the dangers of these technologies to women's health. In the spring of 1988, a special committee of the Bar of Québec presented a report on the main issues raised by reproductive engineering. Lastly, an interdepartmental task force was set up to advise the Minister of Health and Social Services regarding policies to deal with the staggering development of new human reproductive technologies. After the task force submitted its report in June 1988, the Minister made her department's positions public.

The President of the Conseil du statut de la femme played an active role in the work of the task force, defending the positions developed by the Conseil. In April 1988, she called attention to the strong opposition to some of the Conseil's recommendations, expressing the hope that: **not only the experts, but women as well be heard concerning these fundamental questions, which put the reproductive process of the human species to the test as never before.**²

In 1989, the Conseil entered a second phase in which it hoped to maximize the impact of its efforts over the previous three years to explore the question in more detail. The goal of its action plan for the coming years is to strengthen all its positions in regard to reproductive engineering and prenatal diagnosis, and to make them known.

At a time when the Québec government should be taking a stand on these crucial medical, social and ethical questions, when it is called upon to define its policies and place acceptable limits on these new practices, which affect the future of the human species, the Conseil du statut de la femme believes its positions must be crystal clear.

Québec is not facing this challenge alone, for in most Western countries, the debate is gaining momentum and infatuation with the tremendous progress these technologies have made is giving way to concern. There is a growing urgency about exercising more control over and establishing guidelines for practices and research in reproductive engineering and the qualitative management of births. No one can now afford to ignore the social, ethical and legal implications of these new practices.

Profoundly troubled by the direction that research into artificial procreation has taken, the eminent biologist Jacques Testart — father of the first test-tube baby in France — halted his research into certain aspects of genetic manipulation. In addition to being international in import, his decision threw the scientific community into deep disarray.

1 A complete list of the research reports, other publications and audiovisual presentations prepared by the Conseil, which are available on request, is given at the end of this opinion.

2 Excerpt from the Conseil's unpublished 1985-1988 three-year action plan.

Opinion adopted by the Conseil du statut de la femme at its meeting of May 11 and 12, 1989

Collaboration in the preparation of the Conseil's opinion

Members of the Comité sur les nouvelles technologies de la reproduction

Marie Lavigne, President of the Conseil
Ghislaine Cloutier-Gaumont, Vice-President of the Conseil
Céline St-Pierre, member of the Conseil
Édith Deleury, jurist, professor, Université Laval
Diane Girard, lawyer, Sirois, Lapointe
Marie Gratton-Boucher, theologian, Université de Sherbrooke
Micheline Boivin, Director of Research
Susanne Fontaine, Research Officer
Louise Jacob, Director of Communications
Julie Stanton, Communications Officer
Johann Émond, Director of Consult-Action
Jocelyne Olivier, Secretary of the Conseil

Research and writing : Susanne Fontaine

Editing : Julie Stanton

Translation : Elly Mialon
Ministère des Communications

Legal deposit : 4th quarter 1989
ISBN : 2-550-20203
Bibliothèque nationale du Québec

TABLE OF CONTENTS

Foreword	1	CHAPTER 3	
		In Vitro Fertilization	15
INTRODUCTION		3.1 Present situation	15
Positions of the Conseil	5	3.1.1 IVF: an invasive technology	15
Notes	7	3.1.2 Variants of in vitro fertilization	15
		3.1.3 Clientele for these techniques	15
		3.1.4 Low success rates	15
CHAPTER 1		3.2 Conseil concerns and positions	16
Infertility		3.2.1 A distressing technique for women	16
1.1 Present situation	8	3.2.2 Low success rates and a larger clientele	16
1.1.1 Sterility vs. infertility	8	3.2.3 Loss of control over motherhood: a threat to all women	17
1.1.2 Main factors in infertility and sterility	8	3.2.4 Other major problems	17
1.1.3 Voluntary infertility: a widespread phenomenon ..	9	Conclusion	17
1.1.4 Rise in sexually transmitted diseases among young people	9	Notes	18
1.2 Conseil concerns and positions	9		
1.2.1 A better response to the needs of infertile women ..	9	CHAPTER 4	
1.2.2 Preventing and curing sterility: a priority	10	Preconception Contracts	19
Conclusion	11	4.1 Present situation	19
Notes	11	4.1.1 Surrogate mothers, substitute mothers or preconception contracts	19
		4.1.2 A contract or the leasing of services? The various arrangements possible	19
CHAPTER 2		4.1.3 Legal context	20
Artificial Insemination	12	4.2 Conseil concerns and positions	20
2.1 Present situation	12	4.2.1 Legal context in North America	20
2.1.1 Homologous and heterologous insemination	12	4.2.2 Emotional and human implications	20
2.1.2 Recruitment and selection of donors	12	4.2.3 Buying and selling of human beings	20
2.1.3 Clientele for artificial insemination	12	4.2.4 Alienation of women's rights during pregnancy	20
2.1.4 Practice of artificial insemination	12	4.2.5 Possible effect on perceptions of motherhood and of the reproduction of life	20
2.2 Conseil concerns and positions	12	Conclusion	21
2.2.1 The right to know one's origins and the anonymity of donors	13	Notes	21
2.2.2 Prevention of AIDS: a necessity	13		
Conclusion	13	CHAPTER 5	
Notes	14	Prenatal Diagnosis	22
		5.1 Present situation	22
		5.1.1 Prenatal diagnosis: increasingly widespread and performed earlier in pregnancy	22
		5.2 Conseil concerns and positions	22
		Conclusion	23
		Notes	23

CHAPTER 6

Priorities for Research and Services, and Monitoring of Practices

6.1 Research priorities	24
6.1.1 Embryo research	24
6.1.2 Priority research fields	24
6.2 Priorities in the area of services	24
6.2.1 Preventing and curing infertility : a priority	24
6.2.2 Funding priorities	25
6.3 Monitoring required	25
6.3.1 Monitoring of practices	25
6.3.2 Creation of an advisory body	25
6.3.3 Relevance of a general law	26
Notes	26

Conclusion and Recommendations 27
Publications of the Conseil du statut de la femme Dealing with New Reproductive Technologies, 1985-1988 30

INTRODUCTION

Positions of the Conseil

1. Changing the direction of scientific development

As Francine C. McKenzie, former President of the Conseil du statut de la femme, stated, "henceforth, the human being can intervene in his own origins, deliberately blur his identity, indeed modify himself. The potential is there. For human wisdom, it is five minutes to midnight..."¹ She also believed, "... there is still time to let the protagonists in this crucial drama, the women, have their say. They are the ones whose bodies have been chosen to serve as laboratories, the ones who could ultimately become superfluous in human reproduction."²

Women's concerns are echoed by a number of scientists who are themselves asking more penetrating questions about scientific determinism and the disturbing power they wield. According to scientist Joël de Rosnay:

"... for the first time, biological evolution is no longer determined solely by mutation and natural selection. It can also be determined by man. **Capable of creating new animal and plant species, he has become "an engineer of man", true "magician of genes", which he can program at will. Such power, acquired in so brief a time, poses ethical problems, such as "in vitro" reproduction and the treatment of genetic diseases...** It is also at the root of unprecedented industrial growth founded on a young science whose impact is terra incognita, but which has favoured the development of biotechniques."³

In his work of popular science, in which he tries to answer such basic questions as "What is the origin of life? What is life? Where is life headed?", Rosnay states:

Through natural selection, human beings are perfected, adapt and become more complex in tremendous profusion and an infinite wealth of form and function. Species fight for their lives. Some disappear forever, others are born. Among the most recent is one whose members, having been given a sufficiently large and complex brain, are curious enough to ponder the mystery of their origins... This species is man, a living being endowed with curiosity, but a conqueror and predator as well. His behaviour could endanger not only his own species but his planet, for he now can dictate biological evolution having discovered its very wellspring. The future of life depends, to a great extent, upon him."⁴

Women say they are troubled about "the future of life" and, as those most directly concerned, they are also disturbed by the destiny that science is reserving for their biological function, which is precisely to "give life". They are therefore entitled to ask ques-

tions, given the upheavals generated by the new reproductive technologies.

2. Crucial challenges to women and society

Some of the main challenges facing women and society in regard to new human reproductive and prenatal diagnostic technologies need to be discussed, however briefly. Later we shall elaborate on each theme.

Challenges to women

• *Fragmentation of motherhood*

Motherhood has become fragmented: fertilization, gestation and delivery may now be separate operations, independent of one another. A notable example is the dissociation of reproduction and the sexual act, of fertilization and creation of the embryo through the union of sperm and egg outside the woman's body (in vitro fertilization). Preconception contracts aggravate this dissociation, for the genetic mother, the uterine mother (who carries the fetus) and the social mother are, in extreme cases, three different women. The feminist critiques analysed by the Conseil du statut de la femme highlight how, when the industrial model is applied to reproduction, women's bodies may be dissociated from the whole process: "... the role of women in this model will be gradually reduced to that of a reproductive machine assigned a given function in the 'assembly'. Some women will be selected for the quality of their eggs, others to carry the fetus, without being able to reproduce."⁵

• *Commercialization of motherhood*

The industrialization and "marketing" of motherhood are becoming realities. It is now possible to produce a child on demand, to carry it and to deliver it for a price. The production of children could become a business, part of the market economy, with those involved (sperm and egg donors, contracting mothers) and middle persons (contracting mother agencies, sperm banks, lawyers, physicians and so on) making substantial profits from it.

• *Strengthening of medical power*

Assisted reproduction techniques subject motherhood to medical control. The rationalized management of human reproduction, particularly through artificial procreation, prenatal diagnosis and fetal therapy, legitimizes this medical power.

• *Female guinea pigs*

More docile than a laboratory animal, a woman subjected to the new reproductive technologies becomes, for all practical purposes, a subject of scientific experimentation, on which new drugs are tried that have not even been given to animals. This is true of

the drug Buserelin in France.⁶ The blocking of ovulation and hormonal stimulation constitute, by their very nature, violent acts perpetrated on the woman's body and a threat to her physical integrity.

- ***Exacerbation of the desire for a child***

The desire for a child risks becoming the "right" to have a child. Through the magic of technology, so-called infertile women are enticed by a hitherto impossible dream, which, in most cases, simply generates a need destined to remain unfulfilled. The new reproductive technologies can also give rise to the desire for a custom-made or perfect child.

- ***Bypassing the problem of sterility***

Instead of preventing the growing sterility of women (linked to the rise in sexually transmitted disease, early sterilization, invasive contraceptive methods and so on) or curing it, the problem is bypassed through assisted procreation techniques. The objective of artificial insemination and in vitro fertilization is not to restore a couple's reproductive capacity, but to produce the desired child. This is how one deals with what may be termed the spiralling medicalization of desire: recourse to sterilization (tubal ligation), then to in vitro fertilization in order to fulfil the desire for a child.

Challenges to society

- ***Fragmentation of filiation***

Artificial insemination with a sperm donor divorces biological paternity from social paternity, while artificial insemination with the sperm of several donors irremediably blurs the origin of the child, making any attempt to discover biological paternity destined to fail. Furthermore, the anonymity of sperm donors has grave consequences, since it deprives the child of the right to know his biological origins. And, since the donor cannot be clearly identified, it prevents the detection of hereditary diseases that could be transmitted by the sperm.

- ***Transgression of time***

The freezing of sperm, embryos and, soon, eggs eliminates the notion of time, for it makes post-mortem insemination, the birth of twins at different times and other similar phenomena possible.

- ***Disposal of embryos***

The production of several embryos through hormonal stimulation and the freezing of embryos pose the problem of what to do with the extra embryos. If they are not implanted in the mother's womb, should they be destroyed? If not, will they eventually be marketed, traded or used for research or experimentation?

- ***Eugenics***

Prenatal diagnosis, selective abortion and the manipulation and selection of gametes (banks of sperm to produce future Nobel

Prize winners) enhance the possibility of selecting the sex and genetic characteristics of the child. Experiments on embryos will also further genetic research by multiplying eugenic choices.

In short, these are the multiple challenges of the new artificial reproductive and prenatal diagnostic technologies faces by women and society. Whereas we can scarcely measure the social, ethical and legal impact of these new practices and have not made the required adjustments or set the necessary limits, science continues its unbridled experimentation and new techniques are developed at an alarming rate. We have simply listed the challenges posed by techniques already in existence and widely used. Other challenges will confront women and society in the near future when cloning (the production of identical individuals), ectogenesis (the development of an embryo outside a woman's womb in an artificial uterus) and the production of hybrid species are possible and when genetic manipulation and fetal therapy have been perfected. The animal biology research now under way gives us a glimpse of these possibilities. Once they are realities, their application to human biology will be but a step away.

3. Feminist and humanist perspectives

The study by the Conseil of new human reproductive technologies led it to cast a critical eye on these techniques and the problems they create for women. In its view, the alienation of the reproductive function of women and the threat to their physical integrity are major problems. The Conseil also questions these technological developments from an ethical and humanist perspective. It feels that the issues related to filiation, sex selection, the transgression of time, eugenics and the manipulation of embryos are challenges of the highest order, to which it must address itself.

The Conseil considers the main issues for all women from the perspective of **reproductive autonomy**, i.e. the freedom to choose in all facets of one's reproductive life and the establishment of social conditions that enable women to exercise their individual freedom by acquiring sufficient information, gaining acceptance for their choices, securing better support for the parents of handicapped children and obtaining adequate perinatal care.

With regard to the **physical integrity of women** and their health, the principal demands are more effective and less harmful contraceptive methods, the prevention of infertility and, if necessary, the restoration of women's reproductive capacities rather than the treatment of infertility through new reproductive technologies.

The Conseil therefore favours the **reappropriation of motherhood by women** and believes it is important to insist on treatment for infertility, while preferring biological motherhood. In the Conseil's view, the reappropriation of motherhood also has a cultural and political significance, for women are entitled to express their opinions and have a voice in the direction that these new reproductive practices and research take.

4. Feminist trends and Conseil policies

There have been two main trends in thought about reproduction and motherhood that marked the women's movement.⁷

The first links reproduction to the alienation and oppression of women. It favours means likely to free women from the bonds and burden of this biological function. An early trend in the history of feminism, it has little impact on the present debate.

The second trend considers motherhood: "a bone of contention over which women must claim and maintain control, and an element of their identity... This paves the way for an emancipation of women, not to achieve equality on the male model, but to effect a profound transformation of society, a **reappropriation of maternity as a source of values and power for women**".⁸ While advocating the humanization of birth, the Conseil supports this second trend.

5. Positions of the Conseil

From this standpoint, the Conseil du statut de la femme wishes to make known its positions with regard to the new reproductive and prenatal diagnostic technologies now employed in Québec. The following main themes will be discussed:

- infertility
- artificial insemination and the right to know one's origins
- in vitro fertilization
- preconception contracts
- prenatal diagnosis
- funding and monitoring of practices and research

The present situation in regard to each theme is briefly described and the Conseil's concerns and the positions it defends are discussed. The conclusion summarizes the Conseil's principal recommendations.

The information contained in this opinion has been drawn mainly from various research papers and other publications of the Conseil. Some was also drawn from the report of the task force on new reproductive technologies, prepared by the ministère de la Santé et des Services sociaux.⁹

We wish to thank the researchers and practitioners who were consulted in preparing this opinion. Their insights into developments in prenatal diagnosis and in vitro fertilization were particularly valuable. They are, however, in no way responsible for the content of this opinion.

NOTES

1. Conseil du statut de la femme, F.C. McKenzie, "Crumbling Motherhood", *Dilemmas—When technology transforms motherhood*, Les Publications du Québec, 1987, 38 pp., p. 4.
2. Conseil du statut de la femme, F.C. McKenzie, *Sortir la maternité du laboratoire*, proceedings of the International Forum on New Reproductive Technologies, Québec, 1988, 423 pp., p. 17.
3. Joël de Rosnay, "L'aventure du vivant", Paris, Éditions du Seuil, 1988, 207 pp., p. 159.
4. *Ibid.*, p. 159.
5. Conseil du statut de la femme, Lise Dunnigan, Louise Barnard, *Nouvelles technologies de la reproduction: analyses et questionnements féministes*, March 1986, 161 pp., p. 35.
6. This issue was discussed by biologist Jacques Testart at the International Forum on New Reproductive Technologies in October 1987.
7. Dunnigan, Barnard, *op. cit.*
8. *Ibid.*, p. 5.
9. *Rapport du Comité de travail sur les nouvelles technologies de la reproduction*, Direction générale de la planification et de l'évaluation, ministère de la Santé et des Services sociaux, Québec, 1988, 120 pp.

CHAPTER I

Infertility

The search for a way to overcome the sterility or infertility of couples is not a new challenge. Isolated attempts have been made over the past two centuries. However, since the Second World War, efforts have been on a grander scale, and the new reproductive technologies are now commonly heralded as curatives in treating infertile couples. Sterility, infertility, idiopathic infertility, hypofertility... what are the meanings of all these mysterious terms for a reality about which little is known? These terms will be defined, the experiences of infertile women in Québec will be related and the Conseil's main concerns and positions in this area will be discussed.

1.1 Present situation

1.1.1 Sterility vs infertility

Sterility is defined as "the inability of a human being to procreate or reproduce".¹

Infertility refers to "an inability to conceive or become pregnant after normal sexual relations without using a contraceptive method for one full year".¹

Sterility is the medically demonstrated **individual inability** of the man or the woman to procreate. Infertility concerns the couple and is much broader and variable since it involves the concept of time. The observation period is generally one year in North America, including Québec. The World Health Organization, however, advocates a period of two years, which would considerably reduce the number of infertile couples.

1.1.2 Main factors in infertility and sterility

The study conducted by the Conseil² highlights the following data, which refer to **couples** and are drawn from the various sources analysed:

- **33 % to 40 %** of the factors in infertility are attributable to the **man**;
- **45 % to 60 %** of the factors in infertility are attributable to the **woman**;
- **15 % to 20 %** of the factors in infertility are attributable to **both partners equally**.

The factors in female and male infertility and sterility vary.

In **men**, they may be linked to:

- the inability to produce normal sperm (spermatogenesis);

- malfunctioning of the excretory canals, making it impossible for normal sperm to be excreted;
- deficient sexual relations.

In **women**, they may be linked to:

- ovarian or ovulatory factors: the absence of ovaries, eggs or ovulation;
- tubular factors: the absence of tubes or their obstruction; one major cause of tubal obstruction seems to be infection, such as salpingitis, sexually transmitted disease or endometriosis;
- uterine factors, i.e. the absence or malformation of the uterus;
- cervical factors, i.e. cervicitis or inflammation of the cervix.

The term **idiopathic infertility** has also entered the medical vocabulary to designate **infertility of unknown cause or that has not been medically demonstrated**. As a study by the Conseil notes: "there are definite diagnoses of fertility and infertility..., but, in certain cases, factors other than clinical ones or unidentifiable clinical factors must be considered. The effect of stress, the emotions and certain psychological and social factors on conception is little known, but cannot be denied."³

Increasingly flexible, the concept of infertility covers an ever expanding range of women. **Furthermore, a vague diagnosis of idiopathic or unexplained infertility may motivate couples to seek help via the new reproductive technologies with no specific medical diagnosis, thereby making the infertility rate as high as 30 % in certain clinics, while these couples may in fact be fertile.**

Laurence Gavarini analysed this phenomenon in a paper delivered at the International Forum on New Reproductive Technologies.⁴ She noted, in fact, that the physicians most committed to reproductive biotechnologies are themselves astonished by the number of women who become pregnant "naturally" after failing to become pregnant through artificial fertilization or while they are on the waiting list. This is what Frydman calls "surprise packages". **Studies show, according to Gavarini, that: "the best remedy for infertility could simply be the passage of time, that is, being patient and waiting long enough to become fertile and fecund, particularly after using a contraceptive."**⁵

Considering the "curative virtues" of time, Gavarini is disturbed by the growing use of invasive techniques like in vitro fertilization, which were formerly reserved for clearly diagnosed cases of female sterility (tubal sterility). She notes that, at the present time, 16 % of the patients on whom these techniques are used are males who have been diagnosed as sterile and 24 % are males or females with other diagnosed problems, including idiopathic infertility. We should obviously be troubled by this shift toward the use of increasingly invasive techniques for increasingly vague medical diagnoses.

1.1.3 Voluntary infertility: a widespread phenomenon

Voluntary sterilization is a major factor in female infertility. Tubal ligation has proved to be one of the most widely used contraceptive methods in Québec. The frequency of tubal ligation according to age groups for the years 1985 to 1987 is illustrated in the following table.

Table 1

Frequency of voluntary sterilization of women by age group Tubal ligation (1985 to 1987)

AGE GROUP	1985	1986	1987
Under 15	—	—	1
15-19	35	46	35
20-24	1 035	956	845
25-29	5 435	4 806	4 491
30-34	7 966	7 105	6 766
35-39	5 483	5 006	4 605
40-44	1 788	1 629	1 535
45-49	276	249	274
50-54	23	21	17
55 and over	—	—	5
TOTAL	22 041	19 818	18 574

Source: Régie de l'assurance-maladie du Québec, Service des statistiques, February 1988, Unpublished data.

A major phenomenon that has remained constant over the past three years is that nearly one woman in three who underwent a tubal ligation was under 30. There was also a highly significant number of women (approximately 1000 a year) who underwent the procedure before 25. The same is true for men. In 1985, of the 17 981 men who underwent vasectomies, 3 435 were under 30, or more than one in five. Since the operation is more or less irreversible and there is a low success rate for reanastomosis, a high proportion of men and women are sterilized at a young age and remain so throughout their reproductive years. This phenomenon has grave implications since age and a change of partner may make the men and women regret their decision. In some fertility clinics, an estimated one-third of the candidates for *in vitro* fertilization are women who have undergone a tubal ligation and, having changed their minds, want to have a child. In the case of the men, there is the possibility of collecting and stocking the sperm before they undergo a vasectomy, to make artificial insemination of their partners feasible at later date. There is every indication that the growing use of new reproductive technologies will motivate more men and women to seek help from what may be called the "spiri-

alling medicine of desire", i.e. sterilization followed by recourse to new reproductive technologies.

Lastly, the use of so-called invasive contraceptive methods could also become a factor in sterility. It is acknowledged that the IUD can cause infections that may result in infertility.

1.1.4 Rise in sexually transmitted diseases among young people

The greater exposure of young people to sexually transmitted diseases (STDs) at an increasingly early age and the lack of prevention are commonly seen as the causes of the spread of infertility, particularly in women. The rise in cases of tubal obstruction in women is often associated with the growth in STDs.

Chlamydia trachomatis is a particularly insidious disease that is difficult to diagnose in its early stage. If it is not diagnosed and treated in time, it can result in a significant number of cases of salpingitis, which is a major cause of infertility in women. Often contracted at the beginning of the period of fertility, it can prevent many women from conceiving a child later on, forcing them to seek help from the new reproductive technologies. Studies conducted in Québec show that a great many young people are carriers of the disease without being aware of it and are likely to transmit it.

In the wake of the Conseil's recommendations, the ministère de la Santé et des Services sociaux ordered the mandatory reporting of cases of chlamydia. However, this decision involves no free or mandatory treatment. It will be recalled that the Conseil has criticized the lack of any real programs to prevent STDs, particularly among young people, and has made practical proposals to correct the situation.

1.2 Conseil concerns and positions

1.2.1 A better response to the needs of infertile women

Women often view infertility as shameful in several ways. For many, being a mother is of the utmost importance from a human and social standpoint. The study by the Conseil of infertile women gauged the significance of this psychosocial aspect of motherhood. One spoke of an "infertility crisis". As an article entitled "The will... but no way" in the Conseil's publication *Dilemmas* states: "Infertility is hard to live with, hard to understand, hard to deal with. Identified with women more than men, hardly a stranger to sexual behaviour and lifestyles, subject to a battery of tests and hormonal treatment, infertility is perceived as an obstacle that must be overcome regardless of cost."⁶ The Conseil's survey of 32 infertile women shows that their desire for a child is similar to that of other women, "but it differs in that it is unfulfilled, that they have failed and that they are suffering a loss affecting all facets of their lives: their self-image, social status and sex life, their rela-

tions with their partner, their physical and psychological health, their relations with family and friends and their professional lives.⁷

The Conseil believes that the treatment of infertility solely through medical techniques does not take into account major psychosomatic factors. The prevalence of cases of idiopathic infertility reflects our lack of knowledge about the causes of this problem and about the proper treatment for it. Given the diverse causes of infertility in couples, more extensive preventive, therapeutic and diagnostic measures must be taken, rather than resorting so frequently to reproductive technologies, as seems to be the case at the present time. As we will see, these technologies have exceedingly low success rates and very often create false hopes while causing considerable physical discomfort and side effects in women. They are designed, for all practical purposes, not to cure or prevent infertility, but to bypass the problem by procuring the desired child. **We believe that, before invasive procedures are resorted to, consultation and support services that are much better suited to the needs of infertile couples and women in partiucular should be available.**

Participants in the International Forum on New Reproductive Technologies, held under the aegis of the Conseil, stressed: "the isolation and lack of support or consideration that these women experience, as if, in one more instance, what they were going through were perceived solely as a physiological or medical process with no human implications. The attitude of gynecologists was also mentioned; they feel powerless if they cannot regulate the whole process so that it jibes with their own schedule, thereby, for example, excluding the waiting and observation periode preceding a procedure or reducing it inordinately. Gynecologists who believe there are psychosomatic factors involved always recommend two years of observation. Physicians also tend to neglect research into and comprehension of the non-physiological factors in infertility."⁸ It was mentioned at the Forum that women must begin networking, particularly those committed to resisting the new reproductive technologies and those who are infertile. These new alliances could give rise to useful alternatives. **An effort should also be made to find new ways to resolve the "infertility crisis" and to find valid, more accessible alternatives to fulfil the desire of infertile couples for a child. For example, national and international adoption should be facilitated and new forms of parenting should be encouraged.**

1.2.2 Preventing and curing sterility: a priority

A number of major trends underlying the present development of new human reproductive technologies are particularly disturbing to the Conseil. For example:

- the broadening of the concept of infertility, which has resulted in more people seeking help from artificial procreation techniques;
- the growing incidence of sexually transmitted disease, which could mean that a greater proportion of women, particularly young ones, will have difficulty reproduc-

ing;

- the significant number of women who undergo voluntary sterilization early in their reproductive lives, which could mean greater recourse to in vitro fertilization later on.

In the opinion of the Conseil, we must take precautions against these trends. From this perspective, the struggle against the infertility of couples and the growing sterility of women in particular is a priority. This is why the Conseil feels it is essential to reiterate some of the positions and recommendations it defended in its brief to the health and social services task force.⁹

In regard to contraception and sterilization, the Conseil:

- condemns the excessive use of so-called invasive contraceptive methods and irreversible operations (sterilization), and is disturbed by the many Québec women 20 to 44 years of age who have undergone tubal ligations;
- recommends that research be directed toward developing reliable, temporary, non-invasive contraceptive methods.

In regard to the prevention of sexually transmitted diseases, the Conseil:

- recommends that the prevention and treatment of sexually transmitted diseases, particularly chlamydia, be encouraged and that information and prevention campaigns, directed particularly at young people, be conducted.

In regard to infertility, the Conseil:

- recommends that funding be provided for research into the causes, prevention and treatment of female and male infertility;
- proposes that women be given all relevant information about the treatment of infertility and the procedures required, and that the services be dispensed with the greatest possible consideration for the patient.

Conclusion

According to the Conseil, safeguarding the reproductive capacity of women must be one of the priorities of the Québec health care system in the coming years. The Conseil has insisted that emphasis be placed on the prevention and treatment of sexually transmitted diseases. More recently, it has urged the Minister of Health and Social Services and the Minister of Education to take effective steps for the prevention and detection of sexually transmitted diseases in colleges and universities and to better coordinate their action.

Lastly, the Conseil has recommended that there be a two-year waiting period of regular sexual relations with no pregnancy before couples are given access to fertility clinics. Too short a waiting period (one year) may bring couples to the clinic who are impatient rather than infertile, and encourage premature recourse to the new reproductive technologies without clear diagnoses. There are several indications of a trend toward such recourse by couples who are, in fact, fertile.

NOTES

1. Sylvain Gagnon, "Aspects cliniques : rapport médical", *L'insémination artificielle thérapeutique*, PUL, Québec, 1983, 217 pp., pp. 34-35.
2. Conseil du statut de la femme, André Jean, *Nouvelles technologies de la reproduction — Pratiques cliniques et expérimentales au Québec*, Québec, 1986, 98 pp., p. 8.
3. Ibid., p. 7.
4. Conseil du statut de la femme, Laurence Gavarini, paper delivered in Workshop C, "The children I'd want — if I could", *Sortir la maternité du laboratoire*, proceedings of the International Forum on New Reproductive Technologies, 1988, 423 pp., pp. 120-126.
5. Ibid., p. 125.
6. Conseil du statut de la femme, *Dilemmas — When technology transforms motherhood*, Les Publications du Québec, 1987, 38 pp., p. 8.
7. Conseil du statut de la femme, Françoise-Romaine Ouellette, *Les enfants que je veux... si je peux...*, January 1987, 184 pp., p. 55.
8. Conseil du statut de la femme, Lise Dunnigan, "Synthèse du débat", Workshop A, "Crumbling Motherhood", *Sortir la maternité du laboratoire*, proceedings of the International Forum on New Reproductive Technologies, 1988, 423 pp., p. 88.
9. Conseil du statut de la femme, Mémoire présenté à la Commission d'enquête sur les services de santé et les services sociaux, Québec, 1986, 64 pp.

CHAPTER 2

Artificial Insemination

An ostensibly simple technique, artificial insemination has been in use for over 20 years. The procedure consists in introducing healthy sperm into a woman's genital tract in the absence of sexual intercourse. The sperm are deposited in the cervix or at the entrance to the uterus during ovulation. The technique may be accompanied by hormonal stimulation. It requires few technical procedures. In fact, a woman can even carry out self-insemination. Certain women's groups in the United States advocate this practice. Over the past few years, several variations of the procedure have been developed to meet the ever-increasing needs of infertile and fertile couples, and single women.

However, a word of caution is in order! Although the procedure seems simple, it raises important medical, social and legal questions, which are discussed below.

2.1 Present situation

2.1.1 Homologous or heterologous insemination

Artificial insemination is above all a palliative for male infertility¹ and, in the case of hormonal deficiency in a woman, hormonal stimulation can be used to cause ovulation.

Homologous insemination (with the spouse's sperm) is prescribed if the male is infertile or hypofertile, i.e. if there are not enough sperm, their motility is low or malformation prevents them from reaching the egg during sexual intercourse.² A sufficient number of sperm are then collected, either by masturbation or in the urine (in the case of retrograde ejaculations) and used to inseminate the spouse.

2.1.2 Recruitment and selection of donors

In Québec, the criteria for the selection of donors vary little from one centre to another. A high quality spermogram is required, and there must be no history of serious genetic or venereal disease. A psychological test is also administered to check the donor's motivation.³ The donor participates voluntarily. He promises to provide information about his physical condition and will receive compensation (\$25 to \$50) for his travelling expenses each time his services are required.

In actual practice, when circumstances permit, an attempt is made to find a donor "whose characteristics match those of the spouse as closely as possible".⁴ In Québec, donors are mainly recruited from among medical students and health care personnel. A donor may provide sperm for the conception of no more than

about 10 children. Data concerning the donor are kept by the urologist for an undetermined period of time, and anonymity is mandatory.⁴

2.1.3 Clientele for artificial insemination

As a general rule, artificial insemination in Québec is reserved for stable couples, and both spouses must sign a written consent. There are, however, two clinics that will inseminate single and homosexual women.

2.1.4 Practice of artificial insemination

According to the Conseil's study, there were 11 specialized centres in Québec in 1985 that practised both homologous and heterologous artificial insemination. According to the report by the task force of the ministère de la Santé et des Services sociaux, 37 hospital centres billed the Régie de l'assurance-maladie du Québec in 1985 for artificial insemination. From 1979 to 1984, the number of cases of homologous and heterologous insemination for which the Régie de l'assurance-maladie du Québec was billed nearly doubled, from 3 828 to 6 810. The total number in the six years was 34 505.⁵ These figures do not indicate, however, the number of women inseminated, for the same woman could have been inseminated three times per cycle with the sperm of three different donors, and could have gone through several cycles (an average of three) before she became pregnant. The report by the task force notes that the success rate, calculated on the basis of the number of births compared with the number of women inseminated during one cycle, is about 4.7%.⁶

2.2 Conseil concerns and positions

Although artificial insemination is a relatively simple technique, it may raise major social, ethical and legal questions:

- **homologous post-mortem insemination** raises the problem of the transgression of time, since the woman is inseminated after the death of her spouse. According to the Conseil, this practice is unacceptable because it means the child will be born after the death of the male spouse and is therefore a negation of death;
- **the buying and selling and importing of sperm, the creation of sperm banks and the absence of control** are also troubling;
- **practising eugenics and selecting sperm donors** according to certain physical, intellectual or other characteristics are also disturbing. Practices aimed at matching the characteristics of the donor and those of the social father help to blur the biological origins of the child. They are inconsistent with the objective of informing the child of his origins;
- **couples, even fertile ones, are offered the possibility of selecting the sex of their child** by mixing the gametes of the male spouse and the donor;

- there is a danger of contaminating the sperm with the AIDS virus ;
- problems in regard to filiation and the anonymity of sperm donors may arise.

2.2.1 *The right to know one's origins and the anonymity of donors*

The legal questions raised by sperm donor anonymity and the problems related to the recognition of paternity have been discussed in countries where the new technologies are becoming widespread. A notable example is Sweden, where legislative provisions to eliminate the anonymity of sperm donors have been adopted. Finland will soon consider a bill with the same objectives.

In Québec, the filiation of a child conceived through artificial insemination is legally protected, since it is established mainly by the act of birth and legitimacy. The social father is recognized as the father of the child. However, the child has no recognized right to know his biological origins if he is conceived by means of artificial insemination with a donor. The anonymity of sperm donors is thus guaranteed, and there is no recognized system for collecting and conserving social and medical data about them. Furthermore, practices in which a woman is inseminated three times in two days with the fresh sperm of three different donors irremediably blur the biological origins of the ensuing child, making any attempt to discover his biological paternity futile. This is also a grave problem from a medical standpoint, for it is impossible to trace the true donor in the case of a serious hereditary disease. **It is therefore recommended that, in the future, only one sperm donor be used in any given cycle.**

It seems obvious that these practices should be altered so that the biological origins of the child can be established.

With this mind, the Conseil submitted an opinion to the government in 1987 in which it made concrete proposals for the elimination of the anonymity of sperm donors.⁷

The Conseil recommends that specific legislative amendments be adopted so that artificially conceived children can find out their origins when they come of age ; the children should be entitled to obtain, upon request, as of the age of 14, a summary of their sociobiological antecedents, and their adoptive parents should be entitled to obtain a copy of the summary upon the birth of the child. The Conseil believes that, except in special circumstances, all information concerning an adopted or artificially conceived child should remain confidential. The legislative amendments proposed by the Conseil should not be retroactive or create legal bonds between the parents and the child.⁸

The following conditions must be met if these recommendations are to be implemented :

- current artificial insemination practices must be changed ;
- articles 631 and 632 of the Civil Code must be amended to include the new provisions ;

- a central data bank must be created for all pertinent information about sperm donors.

The Conseil believes that action must be taken at once, for if all the provisions are in force by 1990 at the earliest, only the rights of children who come of age in the year 2008 and thereafter will have been established.

2.2.2 *Prevention of AIDS : a necessity*

The Conseil hopes to see women's health protected by preventing transmission of the AIDS virus (the human immunodeficiency virus [HIV]) through a donor's sperm. A study by the Conseil noted that four cases of transmission of the virus by donor sperm had been reported in Australia.⁹

The tests now in use (Elisa, Wester-Blot) do not detect the virus in the blood, only antibodies consecutive to contamination by the virus. It is estimated that the formation of a sufficient number of these antibodies can take two or three months or even more after contact with the virus. This is what is known as the "risk window". An initial test to detect the virus in the blood of the sperm donor may therefore be insufficient. The donor must be tested six months later to be certain that his sperm are not infected. Adequate screening for the AIDS virus therefore requires **the use of frozen sperm only, from a donor whose blood has been tested at six-month intervals before artificial insemination takes place.**

In the Conseil's view, preventing the transmission of AIDS by donor sperm in order to protect women's health is crucial, given the continual spread of the disease. The figures also indicate that a large proportion (61 %) of the heterosexuals in Canada who carry the AIDS virus are in Québec.

Conclusion

In addition to these specific recommendations, the Conseil has made the following general proposals in regard to artificial insemination :

- **that access to artificial insemination with a donor be limited to couples with a demonstrated fertility problem or with a high risk of transmitting a serious hereditary disease** (this excludes single and homosexual women, as well as men and women suffering from idiopathic infertility) ;
- **that the practice be limited to specialized centres**, either public or private, that are governed by the same regulations (this excludes private medical practices) ;
- **that donors be selected on the basis of medical criteria and after a clinical interview**, during which they are made to realize the significance of what they are doing ;
- **that sperm donors receive no remuneration ;**
- **that the number of times sperm from one donor are used be limited to ten, or two births) ;**

- that the **written consent** of the couple be obtained ;
- that the conditions required for the **elimination of anonymity** be respected in the case of artificial insemination with a donor, i.e. that the practice of mixing sperm be prohibited and that nominative medical and non-medical data be collated ;
- that the child be given **access to nominative medical and non-medical data upon request** when he comes of age and that the parents, and the child when he turns 14, be given access to non-nominative medical data.

Lastly, the Conseil recommends :

- that **practices aimed at sex selection for the sake of convenience** be prohibited, with the exception of cases of serious sex-related hereditary diseases.

NOTES

1. Conseil du statut de la femme, André Jean, *Nouvelles technologies de la reproduction — Pratiques cliniques et expérimentales au Québec*, Québec, 1986, 98 pp., p. 28.
2. *Ibid.*, p. 29.
3. *Ibid.*, p. 30.
4. *Ibid.*, p. 31.
5. *Ibid.*, p. 34.
6. Direction générale de la planification et de l'évaluation, ministère de la Santé et des Services sociaux, *Rapport du Comité de travail sur les nouvelles technologies de la reproduction*, Québec, 1988, 120 pp., p. 37.
7. Conseil du statut de la femme, *Mémoire portant sur le droit de connaître leurs origines pour les enfants adoptés ou conçus au moyen d'une technique de procréation assistée*, May 1987, 25 pp.
8. Conseil du statut de la femme, *Position du Conseil du statut de la femme sur les nouvelles technologies de la reproduction humaine*, April 1988, 3 pp., unpublished.
9. Conseil du statut de la femme, Éric Laplante, *Étude sur les femmes et le sida et recommandations du CSF*, August 1987, p. 2, unpublished.

CHAPTER 3

In Vitro Fertilization

The first test-tube baby was born in Great Britain in 1978. It is estimated that, in 1988, approximately 3000 children were born throughout the world by means of in vitro fertilization.¹ The first test-tube baby in Québec was born in 1985 and IVF dates back to 1979.² There are essentially two steps in this procedure. The first is **fusion** in a petri dish of an **artificially removed egg and a sperm**. The second is the **transfer of the embryo** thereby produced to the woman's uterus. However, for these operations to be successful, several other kinds of treatment are required. The woman must be closely monitored and subjected to complex procedures and hormonal "boosting", when powerful medication is administered, first to block the ovulatory cycle, then to cause hyperovulation. As we shall see, this is an invasive technology with considerable repercussions on the physical integrity of the woman, and we feel it is still, from several standpoints, in the experimental stage.

3.1 Present situation

3.1.1 IVF: an invasive technology

The Conseil's research on clinical and experimental IVF practices in Québec indicates that, at the present time, IVF teams³ use superovulation so that several follicles mature and the ovulation process can be completely controlled while maximizing the effectiveness of the technique. In the natural ovulation process, only one ovum is obtained, and it is sometimes removed too early or too late for effective fertilization.

With IVF, women are subjected to a highly invasive procedure for hormonal stimulation,⁴ beginning on the first day of the cycle and ending 13 to 14 days later in the puncturing of the follicles. This treatment requires meticulous monitoring of follicle growth through ultrasonography and daily doses of hormones so that the eggs can be removed at the most auspicious time. The woman must stay near the hospital and, if she lives some distance away, she must pay her own living expenses.

The removal of the ova from the follicle is then carried out through laparoscopic surgery (a laparoscope is introduced through the abdominal wall and the pelvic cavity is filled with air) under general anesthesia. A less invasive technique may also be used: vacuuming (puncturing) of the follicles with ultrasonographic control through the natural canals under local anesthesia. Next, the sperm are matured so that they can fertilize the eggs. Each egg is then inseminated by active sperm. Sixteen to 20 hours after insemination, it can be determined whether fertilization has taken place.⁵

Implantation is carried out 24 to 48 hours after fertilization by means of a catheter through the uterine opening. In practice, more than one embryo is implanted (in Québec, clinics implant an average of 1.9 to 2.9 embryos and no more than three to six).⁶ The embryos not implanted are frozen for later use.

At each stage of the cycle, the woman may face failure. She may respond poorly to hormonal stimulation, the egg may not be fertilized or the embryo may not be properly implanted in the uterus. The whole process must then be started over again. Some women undergo the procedure twice, some up to five times.

3.1.2 Variants of in vitro fertilization

Two procedures derived from in vitro fertilization are now practised:

- **In vivo fertilization** (gamete intrafallopian transfer or GIFT) is distinguished from in vitro fertilization in that the sperm and eggs are transferred together by means of laparoscopy to the tubes, which are their natural site of fertilization. This technique must be used in the case of women who have one intact tube and particularly for idiopathic and male infertility. It may therefore be assumed that the technique is often used on women who are perfectly fertile.
- **the "civette"**, a new variant of IVF developed in France. In this procedure "the eggs and sperm are placed together in a small capsule that is implanted in the vagina".⁷ The vagina serves as an incubator. The capsule is subsequently removed and the embryos are transferred.

The **transfer of the embryo** from one woman to another is a third technique used in several countries, including the United States and Italy. The embryo is expelled from the uterus by uterine lavage and transferred to another woman.

3.1.3 Clientele for these techniques

The main indications for IVF are **irreversible blockage and serious injury of the tubes**. In response to a questionnaire prepared by the task force of the ministère de la Santé et des Services sociaux, the six clinics then practising in vitro and in vivo fertilization in Québec stated that the techniques were used when the following conditions, in order of prevalence, were present:⁸

- **involuntary tubal sterility**;
- **idiopathic infertility (of unknown medical origin)**;
- **male infertility**;
- **endometriosis**;
- **voluntary tubal sterility (tubal ligation)**.

3.1.4 Low success rates

Some practitioners claim relatively high IVF success rates (up to 30%). Some success rates — simply the result of wishful thinking — are calculated using the number of women who be-

come chemically pregnant (according to a pregnancy test) or the number of women who become clinically pregnant (according to the first ultrasound examination). The data collected by the task force of the ministère de la Santé et des Services sociaux indicate that: "among the 596 women who had undergone the procedure, there had been, by the time of the survey, 17 births, including one set of triplets and two sets of twins. There were 13 deliveries in all..."⁹

Calculated on the basis of the number of women who gave birth to one or more live babies, compared to the number of women who were subjected to the hormonal stimulation procedure, **the success rate would be 2.2 %**. The report also notes that the success rate calculated on the basis of the number of live births by all the women who underwent ovarian stimulation varies, depending on the clinic, from 0 % to 5 % for IVF itself and from 0 % to 8 % for in vivo fertilization.¹⁰

3.2 Conseil concerns and positions

The Conseil finds the growing use of in vitro fertilization troubling. Current practices (overmedication, invasive procedures and so on) are very distressing for the women involved. Furthermore, the success rate is still very low and the technique could be too widely used. Lastly, it has serious ethical and social implications.

3.2.1 A distressing technique for women

Numerous **feminists and practitioners** criticize the **many slips between the cup and the lip** and the major problems experienced by women who undergo hormonal stimulation and the other procedures required by in vitro fertilization.

At the International Forum on New Reproductive Technologies, Renate Duelli Klein was particularly critical of the lack of consideration for the women involved: "A woman is indeed a good incubator — one that walks voluntarily into a lab, presents her veins for endless blood samples — (as many as 200, as some women in my study report) — who swallows fertility drugs as told, bears hormone injections and does not dare to complain about 'side effects' such as 'hot flushes and abdominal discomfort or bloating, blurred vision, nausea, nervous tension, depression, fatigue, dizziness and lightheadedness, insomnia, headaches, back problems, and breast soreness'. An incubator that submits herself to an ever increasing battery of new methods such as... 'hormone cocktails'... : mixtures of different hormones to, on the one hand, stimulate the growth of a multitude of egg follicles, but on the other eliminate woman's own bodily functions — that is make her menopausal — in order to then start them afresh with fertility hormones."¹¹ Ms. Duelli Klein reports the case of a woman who, after hormonal stimulation in an IVF program, developed cancer of the ovaries, appendix, uterus and bladder. She cites sources according to which hyperstimulation may cause cancerous cell

growth. She also points a finger at **Chlomid**, the most frequently prescribed follicle-stimulating hormone. Its structure is similar to DES (Diethylstilbestrol), a drug used from 1940 to 1970 to prevent miscarriages, which resulted in three to five million daughters and sons with fertility problems and, in the case of the daughters, with increased incidence of cancer. Biologist Jacques Testart announced at the Forum that he was conducting a research project to experiment with **Buserilin on animals**. Serious experiments with this drug, which is already widely used on women in IVF clinics in France, have never been conducted, even on animals.

Several sources mention the negative effects of in vitro fertilization. According to the research carried out on behalf of the Conseil:¹²

- "in 10 % of the cases, hormonal stimulation causes nausea, vomiting, vasomotor symptoms, headaches, and sometimes vision problems and ovarian cysts";
- the general anesthesia during laparoscopic surgery also has major side effects;
- laparoscopy can cause abdominal bleeding.

Lastly, the **higher rates of miscarriage and multiple births, the major risk of ectopic pregnancy and the risk of abortion related to amniocentesis** should also be mentioned.

The Conseil's research on infertile women found that, during the 15 days that the women undergo hormonal treatment, they are: "extremely tired, not only because of the medication, but because of their daily visits to the hospital for blood samples, ultrasound examinations and injections."¹³ The research also highlighted the serious problems experienced by the women during treatment:

- the impersonal, disjointed care they receive;
- the lack of information;
- the lack of psychological support;
- the excessive pressure or encouragement to continue the treatment. As one woman said: "They don't call you 'patient' for nothing!"¹⁴

3.2.2 Low success rates and a larger clientele

The Conseil feels it should reiterate the two principles underlying its positions and thoughts on the new reproductive technologies: the **physical integrity** of women and their **reproductive autonomy**.

The Conseil believes that, according to the **principle of reproductive autonomy**, it is essential that women be properly and fully informed about the side effects of the techniques and drugs used. It believes that women must also be told the true success rates of in vitro fertilization, calculated on the basis of the number of women giving birth to live children, compared with the number of women subjected to hormonal stimulation during a given cycle, since the objective of the technique is a live birth.

The Conseil feels that, according to the principle of **physical integrity**, the use of in vitro fertilization must be restricted, alter-

natives to hormonal stimulation that are in no way dangerous to women must be found and the practice must be very tightly controlled.

3.2.3 *Loss of control over motherhood: a threat to all women*

Even more than artificial insemination, in vitro fertilization legitimizes the fragmentation of motherhood. Although the technique can fulfil an individual desire for a child, if it becomes generalized, it may have a **negative effect on all women**. The production of the embryo outside a woman's body, the use of the uterus as an incubator, the donation of eggs and embryos, the freezing of sperm, embryos and, soon, eggs, and the manipulation of gametes and embryos are all disturbing realities. They are allowing **motherhood to increasingly slip from women's control**. Frightening, too, is the development of the embryo outside the woman's body, inasmuch as conditions conducive to this development (ectogenesis) could be created. A response to a personal desire, in vitro fertilization is **threat to all women** and the threat will grow as the technology becomes more "productive", more efficient and less experimental. As noted in the Conseil's study: since recourse to artificial reproduction is becoming less expensive, will it be used as an argument in favour of the sterilization of women, even very young women, as a radical alternative to contraception, as a way to provide for the safety of women performing dangerous industrial jobs or as a way to control costs related to the fertility of certain categories of the population...?"¹⁵ With in vitro fertilization, maternity could increasingly escape from **women's control** into that of clinicians. Throughout the procedures, **medical power** is so pervasive that one IVF practitioner took the liberty of stating, as a participant in the Forum reported: "When each baby was born, I insisted on taking it in my arms. I wanted to touch those tiny human beings who had come from test tubes."¹⁶

3.2.4 *Other major problems*

The use of supernumerary embryos and the donation of eggs are two major problems generated by current IVF practices which merit special attention.

Supernumerary embryos: hormonal stimulation causes the production of several eggs which, if they are fertilized, will become embryos. The embryos that are not implanted during one cycle will be frozen for use in a later cycle. How long should these embryos be kept? Who will dispose of the unused ones? Should they be destroyed? Are they in danger of being sold? Should they be given to other couples? Should they be used for research?

Hormonal stimulation and the transfer of several embryos (two to six) also have dangerous consequences. A high number of **multiple pregnancies** are noted when several embryos are implanted and allowed to develop. To resolve this problem, created

by the technique, physicians in European and American clinics, as well as in Québec,¹⁷ practise **embryo reduction** to destroy some of the fetuses during pregnancy.

The **important issue of the status of the embryo** thereby comes to the fore. In particular, the couple's responsibility toward the embryo, the length of time the embryo is kept, prohibition of the sale of the embryo and the method of disposal or destruction of the embryo must be regulated.

Egg donation: the eggs collected through laparoscopy could be donated. Some consider the donation of eggs to be the same as the donation of sperm. However, several people are reticent about this practice, pointing to hormonal stimulation and procedures used to collect the eggs as invasive techniques that are distressing for the women involved. This is why, **considering the abuse that these practices could lead to, the Conseil opposes egg donations.**

Note that **Chedoke McMaster Hospital** in Hamilton has just set up the first **egg bank** in Canada, and a similar bank could be created in Québec.

Conclusion

According to the principles laid down by the Conseil, in vitro fertilization must be limited to couples (heterosexual, married or de facto) and, as proposed for artificial insemination, to those with a demonstrated fertility problem.

IVF should therefore only be used when:

- **a child is desired;**
 - **a couple wishes to have a child.** The integrity of the couple must be protected by limiting IVF to "**couples, the female partner of which has a demonstrated fertility problem**". Furthermore, the Conseil recommends recourse to adoption if the female partner is unable to produce eggs. It opposes the donation of eggs;
 - **the integrity of the woman's body** is respected. Restrictions should be imposed because of the experimental nature of the technique. Moreover, hormonal stimulation and interruption of the ovulation cycle are common practices and very harmful to the woman's body. A palliative, not a curative technique, IVF must remain a last resort (after artificial insemination) in cases of medically demonstrated infertility (excluding idiopathic infertility). In addition, the use of this technique on women whose reproductive system is intact should be prohibited;
 - **the woman's reproductive autonomy** is respected, i.e. women must be able to make a free, informed choice about whether they want the technique to be used. They therefore must be given the most specific information possible about the implications, short, medium and long-term side effects and the true success rates for the technique. Determinism of a medical or technical nature is to be avoided.
- In the Conseil's view, the technique must also resolve the

problem it has created, that of **supernumerary embryos**, so that they are not commercialized in any way. We also oppose the use of the embryos in research.

It should be noted that, **if hormonal stimulation is abandoned**, the problems related to supernumerary embryos and egg donations will be eliminated.

The Conseil considers it essential that in vitro fertilization be restricted. It must remain a technique of last resort, since it fragments motherhood and is very harmful to the female body. The growing prevalence of STDs, which cause infertility and sterility, and the use of invasive and irreversible methods of contraception mean that more and more women will seek help from IVF. To offset the growing use of this technique, it must not only be curbed, but more effort must be made to prevent STDs and to develop non-invasive contraceptive methods.

Lastly, the Conseil's recommendations in regard to in vitro fertilization are aimed at eliminating the creation of supernumerary embryos and restricting the practice to experimentation. These recommendations are based on the guidelines issued by the Medical Research Council of Canada following the International Summit Conference on Bioethics, held in Ottawa from April 5 to 10, 1987. Entitled **Toward an international ethic for research with human beings**, the guidelines stipulate:

Considering the experimental nature of in vitro fertilization, its low success rate and the unknown long term effect of these procedures, which though "therapeutic" in nature for the infertile have implications for the manipulation and control of human life, any work with embryos even as treatment for infertility should be regarded as developmental procedures that are experimental in nature and therefore should be closely monitored.¹⁸

NOTES

1. Quoted in *Rapport au Département fédéral de l'intérieur et au Département fédéral de justice et police*, Commission d'experts pour la génétique humaine et la médecine de la reproduction, Bern, 1988, 148 pp., p. 9.
2. *Rapport du Comité de travail sur les nouvelles technologies de la reproduction*, Direction générale de la planification et de l'évaluation, ministère de la Santé et des Services sociaux, Québec, 1988, 120 pp., p. 52.
3. Conseil du statut de la femme, André Jean, *Nouvelles technologies de la reproduction - Pratiques cliniques et expérimentales au Québec*, 1986, Québec, 98 pp., p. 37.
4. *Ibid.*, p. 37.
5. *Rapport au Département fédéral*, op. cit., p. 9.
6. *Rapport du Comité de travail*, op. cit., p. 55.
7. *Ibid.*, p. 19.
8. *Ibid.*, p. 53.
9. *Ibid.*, p. 55.
10. *Ibid.*, p. 55.
11. Conseil du statut de la femme, Renate Klein, "When Medicalisation Equals Experimentation and Creates Illness: The Impact of the New Reproductive Technologies on Women", *Sortir la maternité du laboratoire*, proceedings of the International Forum on New Reproductive Technologies, 1988, 423 pp., pp. 106-107.
12. André Jean, op. cit., p. 43.
13. Conseil du statut de la femme, Françoise-Romaine Ouellette, *Les enfants que je veux... si je peux...*, January 1987, 168 pp.
14. *Ibid.*, p. 109.
15. Conseil du statut de la femme, Lise Dunnigan, Louise Barnard, *Nouvelles technologies de la reproduction: analyses et questionnements féministes*, March 1986, 161 pp., p. 49.
16. *NRT Alert*, video of the International Forum on New Reproductive Technologies.
17. Francine Pelletier, "Dilemme de l'an 2000", *La Presse*, Montréal, Saturday, January 28, 1989.
18. Medical Research Council of Canada, *Toward an international ethic for research with human beings*, Ottawa, 1988, 93 pp., p. 69.

CHAPTER 4

Preconception Contracts

The phenomenon of preconception contracts is closely tied to the growing use of the new human reproductive technologies of artificial insemination and in vitro fertilization. Formal preconception contracts have been in existence for about 15 years. It is estimated that, in the United States, nearly 25 agencies offer "contracting mother" services and there have been about 500 cases of "mothers under contract". In Québec, the practice is much less widespread and, although the existence of similar agencies cannot be confirmed, there have been many indications that this practice has existed for a few years, such as lawyers' testimony that they have drawn up such contracts and that of physicians who claim they are aware of 10 or so deliveries by "contracting mothers". Moreover, the report by the task force of the ministère de la Santé et des Services sociaux notes that advertisements are placed in daily newspapers by American agencies offering the services of "female Quebecers" in their catalogues, who provide "services at a lower price because expenses are covered by the Québec health care system".¹ Are uteruses being leased and children bought and sold? The problems raised must be studied, and the Conseil felt it should issue specific recommendations to eliminate the practice before it becomes more prevalent.

4.1 Present situation

4.1.1 *Surrogate mothers, substitute mothers or preconception contracts*

The terms used must be clarified in order to better grasp the implications of this phenomenon. Feminist writers feel the commonly used expressions "surrogate mother" and "substitute mother" are misnomers. They claim that a mother under contract is not a "surrogate" or "substitute" for the social mother, but the true mother, since she conceives the child, carries it for nine months and brings it into the world. Furthermore, if the "contracting mother" is indeed a substitute for someone, it is not the mother of the child, but the spouse of the father, as the report by the task force of the ministère de la Santé et des Services sociaux points out.² This shift in meaning tends to minimize the role of the "contracting mother", reducing her to a surrogate, a mere "receptacle", and denying the important biological (she is the genetic and uterine mother) and emotional links she has with the child. The terms "preconception contract" and "contracting mother" are much more appropriate and the Conseil decided, after discussing the matter, to use them.

4.1.2 *A contract or the leasing of services? The various arrangements possible*

The phenomenon having been properly named, the various forms it takes should be described. At the International Forum on New Reproductive Technologies, Margrit Eichler listed the various arrangements possible:³

- **contracting parties** : on the supply side, there is always at least one "uterine mother", while, on the demand side, the situation is not always clear. The contracting party may be (a) a man, (b) a man with a partner who is a beneficiary of the contract, although not a signatory to it, (c) a couple, (d) a woman or (e) a woman and a partner who is a beneficiary but not formally involved in the contract;
- **relations between the parties** : the contracting parties may be perfect strangers, they may be friends, in which case the contracting mother engages in the arrangement in order to render a service to a friend, or they may be relatives. Even in cases where the contracting parties are perfect strangers, a relationship of personal dependence is generally established since the contracting mother is subject to the contract and is often "under supervision";
- **fertilization methods employed** : the most commonly used fertilization methods are artificial insemination (the contracting mother is then the genetic and uterine mother of the child) and embryo transfer (if the couple wants to choose the genetic makeup of the child). The social and biological ties with the child may vary greatly according to the various methods used;
- **social and biological bonds with the child** : Eichler lists the following possible parenthood combinations: (1) if the "contracting mother" is inseminated with the sperm of the social father, the child has one uterine-genetic mother, one social mother and one biological-social father (as in the case of Baby M); (2) if the mother is inseminated with the sperm of a donor, the child will have a uterine-genetic mother, a social mother, a biological father and a social father (if the donor is the uncle of the child, he may be both the biological father and the uncle); (3) if an egg fertilized by the contracting couple is implanted in the uterus of the "contracting mother", the child will have a uterine mother, a social-biological mother and a social-biological father; if the uterine mother is related to the couple (e.g. the South African case in which a grandmother gave birth to her grandchildren), the child will have a uterine mother who may be her grandmother, a social-genetic mother and a social-biological father. Other variations are possible, demonstrating the complexity of the resulting bonds of parenthood;
- **involvement of intermediaries or agencies** : private contractual arrangements are sometimes made by the parties (as in the South African case), or a third party or parties may be involved: a lawyer, who oversees the contract negotiations and who may or may not help in getting the two parties together, or an intermediary or agency specializing in matching contracting mothers with individuals or couples seeking

one, where artificial insemination or embryo transfer is practised, medical personnel are also involved;

- **commercial aspects**: this practice does not always involve money (e.g. the South African grandmother). However, commercial transactions are common and may take the form of remuneration of the contracting mother or remuneration of an intermediary or agency or both. A contracting mother is said to receive about \$10 000 to carry and give birth to a child. The intermediary or agency may receive an equal amount.

4.1.3 Legal context

In Canada, preconception contracts are not legally recognized. These contracts are null and void according to the law as it now stands: "... the freedom and recognized rights of any pregnant woman during her pregnancy and delivery may not be limited by a third party and, after the birth, the only rights that may be asserted in regard to the child are those provided for in the Civil Code."⁴

4.2 Conseil concerns and positions

4.2.1 Legal context in North America

Given the North American legislative and legal context, the Conseil feels it should alert the Québec government to the very serious implications that the creation of jurisprudence similar to that in the United States could have in this field.⁴ The Conseil is also troubled by the recommendation of the Ontario Law Reform Commission that such contracts be recognized and that the various aspects be regulated.⁵ The Commission goes so far as to suggest that restrictions on the mother's conduct during pregnancy (diet, prenatal diagnosis and therapeutic abortion, for example) be provided for in the contract. "The Conseil feels that these are extremely disturbing legal trends not only for women bound by such contracts, but for the status and rights of all women."⁶

4.2.2 Emotional and human implications

According to the Conseil:⁷

An agreement made before conception, binding the mother to renounce the child once and for all upon his birth could create traumatic situations if the mother becomes attached to the child through the physical and emotional experience of pregnancy and delivery; ... Moreover, not much is known, of course, about the longer term consequences for the psychological development of children conceived in this way, whether the children are told about their true origins or one tries to hide them. We also do not know enough about the long-term effects on the various parties concerned, or about the family relationships that ensue.

4.2.3 Buying and selling of human beings

According to the Conseil:⁷

A woman's agreeing to the adoption of her child monetary or other gain raises the problem of the buying and selling of children and the commercialization of human embryos (One American company, whose shares are quoted on the stock exchange, is already involved in this practice), even those removed from women who wish to interrupt their pregnancy. This also implies recognition of a new form of economic exploitation of women's bodies, on the basis of their reproductive capacities. Various surveys suggest that certain categories of women would be likely to agree to such contracts because of economic pressure or to abusive clauses in such contracts, while the biological fathers or contracting couples, who often have higher incomes, would be in a better position to impose their own conditions on the contracting mother and to defend their own interests in any subsequent dispute.

4.2.4 Alienation of women's rights during pregnancy

According to the Conseil:⁷

Preconception contracts may entail the serious infringement of the rights and freedoms of pregnant women. For example, they may involve the waiving of the women's right to agree to or to refuse medical intervention during the pregnancy (examinations, drugs procedures, Caesarian section and so on), the waiving of their right to an abortion and a prior agreement to have an abortion when the biological father wishes one to be performed if a defect is diagnosed in the fetus, or any other form of constraint on the activities of the pregnant women (related to work, diet, travel and so on). Such constraints, if they were acknowledged to be justified for the welfare of the child or as legitimate rights of the biological father, could have dramatic consequences for the rights of any pregnant woman and for the concept of the inviolability of the human being.

4.2.5 Possible effect on perceptions of motherhood and of the reproduction of life

According to the Conseil:⁷

Pregnancies resulting from an egg taken from the female partner of the contracting couple pose even more complex problems, partly because they lead to a dissociation and comparison of the genetic and uterine bonds with the child. The present trend according to a number of authorities, which has been confirmed by a recent American decision, is toward the merging of maternity and paternity by equating the genetic bonds created by the sperm with those created by the egg, thereby reducing pregnancy and delivery to a purely physiological process.

that establishes no significant link between the uterine mother and the child, and no significant right of the uterine mother to the child. This mentality reflects an androcentric perception reproduction and motherhood, which, if it gains adherents, will pave the way for the acceptance of completely extra-corporal human reproduction (artificial uteruses).

Conclusion

In its opinion regarding preconception contracts, the Conseil voiced its concern about the possibility of legislations to legalize such contracts, making them executory. It pointed out that, in civil law as it now stands, these contracts are null and void. The Conseil asked that no new legislation legitimizing preconception contracts be adopted.⁸ This would mean that the freedom and recognized rights of all pregnant women could not be limited by a third party, and, after the birth, the only rights that could be exercised before the Court over the child would be those provided for in the Civil Code.

To prevent preconception contracts and curb their commercialization, the Conseil recommends:

- that section 135.1 of the Youth Protection Act (R.S.Q., c. P-34.1) be amended so that any natural or artificial person involved directly or indirectly in a preconception contract may be found guilty of an offence and may be liable to a fine.⁹

The Conseil is also disturbed by the media's part in the spread of the phenomenon in Québec through the publication of advertisements soliciting candidates for such arrangements. Considering the legal status of these contracts, it feels these advertisements should be prohibited.

Lastly, the Conseil reiterates its recommendation that children who are the result of contracted pregnancies have the right to know their origins, just as artificially conceived or adopted children have.

NOTES

1. *Rapport du Comité de travail sur les nouvelles technologies de la reproduction*, Direction générale de la planification et de l'évaluation, ministère de la Santé et des Services sociaux, Québec, 1988, 120 pp., pp. 65-66.
2. *Ibid.*, p. 65.
3. Conseil du statut de la femme, Margrit Eichler, "Proconception Contracts for the Production of Children — What are the Proper Legal Responses?", *Sortir la maternité du laboratoire*, proceedings of the International Forum on New Reproductive technologies, 1988, 423 pp., pp. 187-204.
4. Conseil du statut de la femme, *Déclaration de principe sur la question des grossesses sous contrat*, declaration in principle adopted by the Comité NTR on April 3, 1987.
5. Ontario Law Reform Commission, *Report on human artificial reproduction and related matters*, Vol. I and II. Ministry of the Attorney General, Ontario, 1985, 390 pp.
6. Conseil du statut de la femme, *Déclaration*, op. cit.
7. *Ibid.*
8. Conseil du statut de la femme, *Les grossesses sous contrat*, opinion submitted to the Minister for the Status of Women, Québec, 1987, 6 pp., p. 5.
9. *Ibid.*, p. 6.

CHAPTER 5

Prenatal Diagnosis

The new reproductive technologies can fulfil not only the desire for a child, but the desire for a perfect child. While in vitro fertilization and artificial insemination allow eugenic choices to be made and certain physical characteristics, such as the sex of the child, to be selected, progress in genetic research may reach the point where it is possible to qualitatively monitor and plan births. **Human genetics gives new meaning to prenatal diagnosis by permitting "quality control" of the developing human being...** "It is becoming increasingly possible, through prenatal diagnosis, to detect slight defects whose prognosis is uncertain. There could eventually be less tolerance of any defect or deviation from the norm, perhaps resulting in deterioration of the status of the handicapped and their parents."¹ The possible generalization of the use of prenatal diagnostic techniques is reason for concern. The side effects of these techniques and the ethical problems they raise suggest that recourse to them should be restricted. This discussion will be limited to the main elements of a study conducted by the Conseil on the subject,² and the principal recommendations arising from it.

5.1 Present situation

5.1.2 Prenatal diagnosis: increasingly widespread and performed earlier in pregnancy

According to the Conseil's study, prenatal diagnostic techniques are widely used, increasingly sensitive and employed earlier and earlier in pregnancy. Here is a description of them:

- **ultrasonography**: a routine technique, it is part of the normal monitoring of pregnancy. In 1985, pregnant women had an average of 1.9 ultrasound examinations.³ Although it is not perceived as a prenatal diagnostic technique, it has all the characteristics of one: "Fetal abnormalities are detected through ultrasonography and the pregnant woman is then faced with the dilemma of whether to continue her pregnancy and give birth a handicapped child."⁴ By means of ultrasounds that penetrate the abdominal wall, this technique provides: "on a screen the image of the fetus in the uterus. The age and size of the fetus, and even the position and sex can be determined."⁵ Some anatomical malformations can also be detected through ultrasonography. The study notes, however, that its diagnostic potential is underutilized, although use of the technique almost tripled, from 67 846 in 1979 to 158 222 in 1985;⁶
- **amniocentesis**: a recent technique whose use has grown considerably since the late 1970s.⁷ "Practised between the 15th and 17th weeks of pregnancy, it consists in removing 10

to 20 ml of amniotic fluid through the abdominal uterine wall. Three types of abnormalities can be detected through amniocentesis: chromosomal (including trisomy 21), genetic (defects in a single gene) and malformations of the neural tube."⁸ Amniocentesis is performed mainly on pregnant women 35 and over. According to the study, if abnormalities are detected through amniocentesis, and abortion is almost always performed;⁹

- **chorionic biopsy**: a product of genetic engineering, this technique has vast diagnostic potential. It allows diagnoses to be made early in the pregnancy through the removal of fetal cells between the eighth and tenth weeks. Samples of the chorion villi are taken through the vagina at the point where the umbilical cord and the placenta meet. In a day or two, the technique: "provides the same information as amniocentesis (excluding the alpha-protein count) and other information through access to the genetic material (DNA) of the embryo..."¹⁰ Chorionic biopsy opens the door to predictive medicine, since it makes it possible to detect, before the child is born, certain diseases that he could have in adolescence or adulthood. The technique has been tested in 11 hospital centres in Canada, and the experiments have been completed, paving the way for wider use.

The importance of chorionic biopsy is obvious in the light of this data, for extensive diagnoses can be obtained very early in pregnancy, when women are often ambivalent about their condition and their future child, and could be confronted with the dilemma of selective abortion.

5.2 Conseil concerns and positions

In addition to listing the **negative effects of these techniques on women's health**, the Conseil's study highlights the **ethical and social problems** that may arise out of the growing use of prenatal diagnosis, including:

- **greater medical power over reproduction**;
- **restrictions on women's free choice in regard to selective abortion**;
- **the standardization of individuals and an increasingly broad definition of the concept of handicap**;
- **intolerance and social exclusion of the handicapped**;
- **generalization of the practice of sex selection (the use of amniocentesis in India has favoured the systematic elimination of female fetuses)**;
- **a shift toward eugenics and fetal therapies.**

The growing use of these techniques clears the way for fetal therapies, predictive medicine and preventive medicine. It also raises questions about women's reproductive autonomy and their physical integrity. Could the fetus become a patient? What will its rights be as opposed to those of its mother?

Conclusion

The Conseil's conclusions and main recommendations in regard to prenatal diagnosis are :

- Whatever prenatal diagnostic technique is used to detect congenital abnormalities, none is free of health risks. The utility, benefits and side effects of these techniques and the moral problems they raise suggest that **recourse to them should be limited to situations in which they are medically required**. Therefore, the Conseil recommends that **ultrasonography** be limited to cases in which it is required, that prior written consent be obtained from the pregnant woman and that its effects on the women and fetuses subjected to it be studied. In regard to **amniocentesis**, the Conseil recommends that the ministère de la Santé et des Services sociaux inform women about the indications for its use, and its benefits and dangers, and that the informed, written consent of the pregnant woman be obtained.¹¹ The same information should be provided about **chorionic biopsy** and written consent should also be obtained before it is performed. In addition, the procedure should be carefully monitored to assess the quality and reliability of the results obtained and to establish the number of spontaneous and induced abortions following the procedure and the grounds invoked for the voluntary interruption of pregnancy.¹²
 - The Conseil recommends that any use of **recognized techniques for selecting the sex of the fetus in artificial human reproduction be prohibited** and that any research whose goal or effect is to select the sex of the fetus be suspended.
- Broader consultation, not limited to the scientific and medical community**, should be carried out in order to draw up general guidelines for the development and practice of prenatal diagnosis in Québec, and women should take part in the preparation of these guidelines.¹³

NOTES

1. *Rapport au Département fédéral de l'intérieur et au Département fédéral de justice et police*, Commission d'experts pour la génétique humaine et la médecine de la reproduction, Bern, 1988, 148 pp., p. 91.
2. Conseil du statut de la femme, Lise Dunnigan, Hélène Valentini, *Le diagnostic prénatal : Recherche et recommandations*, 1987, Québec, 145 pp.
3. *Ibid.*, p. 36.
4. *Ibid.*, p. 7.
5. Conseil du statut de la femme, "Prenatal diagnosis", *Dilemmas — When technology transforms motherhood*, Les Publications du Québec, 1987, 38 pp., p. 25.
6. Dunnigan, Valentini, *op. cit.*, p. 35.
7. *Ibid.*, p. 17.
8. *Ibid.*, p. 11.
9. *Ibid.*, p. 17.
10. *Ibid.*, p. 19.
11. Conseil du statut de la femme, *Positions du Conseil du statut de la femme sur les nouvelles technologies de la reproduction humaine*, Avril 1988, 3 pp., pp. 2-3, unpublished.
12. In the light of chorionic biopsy experimentation, the Conseil adapted its recommendations to take into account the new trend toward broader use of the technique while limiting it to older women (38 and over) who request it in centres that have the necessary equipment.
13. *Positions du Conseil*, *op. cit.*, pp. 2-3.

CHAPTER 6

Priorities for Research and Services, and Monitoring of Practices

The Conseil is justifiably concerned about the development of the new human reproductive and prenatal diagnostic technologies. In the absence of any control, it is to be feared that women will pay the price for the unchecked advance of science. The social, legal and ethical issues raised by the growing use of these technologies are too important to be left to the experts, be they clinicians or researchers. As Minister for the Status of Women Monique Gagnon-Tremblay stressed at the International Forum on New Reproductive Technologies: "It is said that war is too important to be entrusted to the generals. The issues involved in the new technologies are too crucial to be left solely in the hands of the experts."¹

The Conseil therefore considers it urgent that the government define the priorities for research and services, and take the necessary steps to ensure that the practices involved in these new technologies are closely monitored.

The Conseil feels it is in a position to issue recommendations regarding the priorities to be established for research and services, and the type of monitoring if feels is required.

6.1 Research priorities

6.1.1 Embryo research

The task force of the ministère de la Santé et des Services sociaux reported that, according to the available information, no Québec clinic is sufficiently sophisticated to conduct research or experiments on human embryos.² Apparently no systematic survey has been made of research projects under way in Québec clinics, and the Conseil feels that, because of this, research on embryos is still difficult to evaluate and control. Not only is it hard to discover the nature of the research under way, but, because there are few means for monitoring this type of practice, the greatest caution must be exercised. In the Conseil's opinion, **considering the morally questionable nature of this research, a moratorium is fully justified, a systematic survey of all research under way should be made, and the matter should be submitted to an advisory body, whose creation is recommended by the Conseil.**

6.1.2 Priority research fields

Throughout this opinion, the Conseil has affirmed its belief that **priority should be given to preventing male and female infertility.** It hopes that the ministère de la Santé et des Services sociaux and agencies that provide seed money (the FQRS and the FCAR) will **fund, on a priority basis,** research aimed at:

- measuring the incidence of the different types of infertility in the Québec population, particularly among women;
- identifying, with the goal of prevention in mind, the different causes — environmental, occupational, social and so on — of male and female sterility;
- evaluating the incidence of sexually transmitted diseases and the factors in their growth, particularly among young people, with a view to proposing more adequate methods of prevention;
- developing new, reversible contraceptive methods with no negative effects on the reproductive capacities of men and women.

Furthermore, the Conseil hopes that research will be conducted to evaluate more adequately **the medical, social and psychological impact** of the use of the new human reproductive technologies.

6.2 Priorities in the area of services

The **funding and monitoring** of these practices are of prime importance for they are the direct responsibility of the State as legislator and provider of funding for most medical procedures through the health insurance plan.

6.2.1 Preventing and curing infertility: a priority

The Conseil's positions on these two questions are consistent with those it has taken on the accessibility, control of and restrictions on reproductive engineering. The Conseil feels, in particular, that in vitro fertilization is still in the experimental stage and that it is highly dangerous to women. The recommendations regarding the funding and monitoring of the practices take these important limitations into account.

From the standpoint of prevention, action must first be taken in regard to the causes of sterility, such as pelvic infections and sexually transmitted diseases. The long-term effects of invasive contraceptive methods (oral contraceptives and IUDs, which seem to prolong the average waiting period before conception) must also be identified. The new reproductive technologies constitute a response to a situation that we have not tried hard enough to improve. Solutions to the problem of voluntary sterilization must also be found.

While recourse to the new reproductive technologies should be restricted, the development and availability of non-invasive, effective and reversible contraceptive methods better adapted to women's needs must be promoted.

The Conseil du statut de la femme makes a clear distinction between services to prevent and cure sterility and those aimed at palliating it.

Since the State's resources are limited, it is essential that funds first be provided for services for the diagnosis, prevention and cure of sterility. From the viewpoint of "medically required" services (Health Insurance Act), the new reproductive technologies are, we believe, palliative services, which should be supported after preventive and curative services.

Therefore, the Conseil recommends that the Québec government provide priority funding for the prevention of female infertility, particularly by setting up programs throughout Québec to prevent sexually transmitted diseases.

6.2.2 Funding priorities

Considering that the treatment is experimental, we believe that access to in vitro fertilization must continue to be restricted. We also see IVF as a last resort palliative treatment that is not aimed at curing sterility but at allowing a woman to become pregnant. Given the State's responsibilities in health matters (see the Health Insurance Act: medically required procedures), we feel it would be prudent to limit public funding to medical procedures recognized by the Régie de l'assurance-maladie du Québec, i.e. laparoscopy, ultrasonography and the required medical examinations and consultations. As the practice now stands, we feel that medication costs (hormone treatments), the cost of laboratory analyses and other related costs (living expenses) should be charged to the beneficiaries of the techniques. Although we do not question free access to certain services, we feel it is impossible at the present time to recommend that public funding be extended to cover procedures not provided for by the Régie de l'assurance-maladie, such as laboratory analyses, medication and living expenses.

The Conseil therefore recommends that the status quo in regard to the funding of infertility services be maintained.

6.3 Monitoring required

6.3.1 Monitoring of practices

At the present time, there is no control over artificial reproductive practices or services. On the basis of its analysis of the situation, the Conseil recommends that satisfactory control methods be implemented to ensure that the quality of the services is high and that women are given the information required to guarantee their autonomy and physical integrity. The criteria for the recognition and accreditation of specialized centres must be defined, while ensuring that:

- standards are established according to which each centre will collect information and report annually on the number of

women treated, the nature of the treatments, the follow-up provided, the number of births, the success rates, the number of pregnancies, selective abortions, ectopic pregnancies, multiple births, malformations and so on;

- the centres make this information available to their clientele;
- mechanisms for the creation of banks of medical and social data on gamete donors, a method for conserving the data and consultation procedures are established.

To ensure that the practices are adequately supervised, the Conseil proposes that an ad hoc committee draw up monitoring and accreditation standards for all specialized centres. The committee would have a short-term mandate, during which it would establish criteria for the evaluation and monitoring of the conditions under which new reproductive technologies are employed. The multidisciplinary committee would include representatives from the humanities and social sciences, representatives of the legal profession and the feminist research community, as well as disinterested representatives of the medical profession. The standards should be laid down by the ministère de la Santé et des Services sociaux and should provide for the accreditation or recognition of clinics. Follow-up and periodic evaluation would also be necessary. We feel it is essential that only a limited number of centres be accredited.

6.3.2 Creation of an advisory body

Considering that the soaring growth of new human reproductive and prenatal diagnostic technologies has raised many ethical and social questions and that careful, enlightened supervision is required, the Conseil proposes the creation of an advisory body to study the moral issues in particular. It would be given rather broad responsibilities so that other bodies would not have to be created. It would have a mandate to:

- advise the government regarding major issues related to reproductive engineering and the qualitative management of births, but also regarding broader life-and-death issues (eugenics, euthanasia, organ donations, sterilization, genetic manipulations, and so on);
- inform the broadest possible public about these matters. The body should be representative of society, highly credible and independent in spirit. We propose a simple structure consisting of seven representatives from different sectors of society;
- generally evaluate the services offered, according to the annual reports prepared by the accredited centres.

The advisory body would consist of one clinician-researcher, one community practitioner, two experts in social matters and ethics, one legal expert and two representatives of social groups, including at least one person from women's groups concerned by this question. We feel it is essential that the body consist not only of experts, but of particularly credible representatives of society who are well informed about the

social, ethical and legal issues raised by these scientific developments. Women should also be well represented.

Under its mandate to evaluate, inform and advise, the body would carry out the following main duties:

- in regard to the new reproductive technologies:
 - issue opinions of an ethical nature and advise the government regarding any matter related to artificial procreation, the donation of gametes, embryo reduction, the disposal of supernumerary embryos in certain clinics and so on;
 - ensure that information concerning the use of the new reproductive technologies — success rates, characteristics of clientele, number of women treated, nature of treatments, number of births, annual reports of the clinics and so on — is available and disseminated to the general public;
 - establish procedures for monitoring research on new reproductive technologies in hospitals to ensure, in particular, that experimental techniques are subject to approval before they become generalized (as is now the case for medication);
- and from a broader standpoint:
 - ensure that research is conducted on the development of practices involving life-and-death issues, and that the medical, social and ethical impact of these practices is evaluated with a view to using alternatives, if necessary;
 - advise the government on life-and-death issues (eugenics, euthanasia, the donation of organs, sterilization, genetic manipulations and so on) and formulate opinions that add to the discussion of the ethical issues involved.

6.3.3 *Relevance of a general law*

Lastly, the ministère de la Justice should study the relevance of adopting a **general law respecting new reproductive technologies**. The purpose of the law would be to establish **guidelines for monitoring the use and development of new reproductive technologies**. The ministère de la Justice should study the legislation in other countries in this domain, especially that which the **Finnish parliament** will soon table, which the Conseil feels is particularly apropos since it contains a set of provisions similar to those proposed in this opinion. It notably provides for:³

- the prohibition of preconception contracts;
- a mandatory permit for the practice of artificial procreation;
- limited access to artificial procreation techniques by heterosexual couples who cannot have children by other methods or have a serious hereditary disease;
- optimal conditions for the development and education of the child;
- the recognition of paternity;
- the mandatory consent of the couple for in vitro fertilization and the use of the gametes of the couple only;
- the mandatory consent of the sperm donor;

- the right of children conceived through this technique to know their origins;
- the monitoring of the stocking of embryos and gametes, as well as of research on embryos.

NOTES

1. Conseil du statut de la femme, **Sortir la maternité du laboratoire**, proceedings of the International Forum on New Reproductive Technologies, 1988, 423 pp., p. 333.
2. **Rapport du Comité de travail sur les nouvelles technologies de la reproduction**, Direction générale de la planification et de l'évaluation, ministère de la Santé et des Services sociaux, Québec, 1988, 120 pp., p. 71.
3. *Proposal for legislation on the techniques of human artificial procreation*, Working group of the Ministry of Justice, Helsinki, Finland, July 1988, 3 pp., unpublished.

Conclusion and Recommendations

Major social challenges

The practices that we have studied constitute the first stage in an important biological revolution. The Conseil believes that **vigilance is essential**. Scientist Joël de Rosnay compares this revolution to that which took place in physics 20 or 30 years ago after atomic energy was discovered. Calling for greater vigilance and "more compassion", he believes that discussion of the fundamental strategic, ethical and philosophical aspects of biological research is urgently needed. For the first time, he says, man is "the engineer of man", and his power is as great as that bestowed when the energy of matter was discovered. "We must think deeply about what we are in the process of doing".¹ The Conseil du statut de la femme believes that women are most directly affected by these urgent matters and that they must take part in the debate, for discussion of the issues should not be confined to the secrecy of the laboratories.

Major political challenges

The Conseil has urged the government to adopt the legislative and administrative measures required to provide the conditions that protect the physical integrity and reproductive autonomy of women, and the identity of children conceived through assisted procreation techniques.

Recommendations

The following is a summary of the main recommendations of the Conseil, listed under the themes discussed in this opinion. There are a number of general recommendations that concern the government and are within the jurisdiction of the various departments. The Conseil feels these are priorities because they lay the foundation for a general policy on new reproductive technologies. The other recommendations deal with the different conditions under which new reproductive technologies should be employed.

1. Infertility

Priority should be given to the prevention and treatment of infertility.

The Conseil recommends :

- 1.1 that the ministère de la Santé et des Services sociaux, in collaboration with the agencies concerned, give priority to the prevention and treatment of sexually transmitted diseases, particularly chlamydia, among young people, notably :
 - that it review existing programs and improve their effectiveness ;
 - that it provide additional funding for the prevention and treatment of STDs in order to offer free medication and services ;
 - that it provide adequate services throughout Québec ;
 - that it conduct information and education campaigns, particularly for those at risk ;
- 1.2 that the ministère de la Santé et des Services sociaux and the agencies concerned make the medical profession, and men and women generally aware of the **consequences of sterilization** (tubal ligation, vasectomy and so on) and the use of **invasive contraceptive methods** (IUD, the pill and so on) ;
- 1.3 that the ministère de la Santé et des Services sociaux and the agencies that provide grants favour **research into the development of non-invasive and reversible contraceptive methods** ;
- 1.4 that the departments concerned and the agencies that provide grants finance **research into the causes** (environmental, occupational, social and so on) **and treatment of male and female infertility** ;
- 1.5 that the ministère de la Santé et des Services sociaux take the necessary steps to ensure that fertility clinics :
 - adequately inform women and couples about the treatment for infertility and the effects of the medication ;
 - give women and couples true support and psychosocial supervision ;
 - increase to two years the period of non-conception required for the admission of infertile couples.
- 1.6 that the agencies concerned develop alternative responses to the desire for a child of infertile couples and conduct research to this end.

1. Interview with Joël de Rosnay, "Les progrès de la biologie exigent un surcroît de vigilance", *Le Devoir*, Monday, January 30, 1989.

2. Artificial insemination

Priority should be given to informing the potential clientele, protecting the physical integrity of women and providing for the security of the child.

The Conseil recommends :

- 2.1 that access to artificial insemination with a donor be limited to couples with a demonstrated fertility problem (excluding idiopathic infertility) or with a high risk of transmitting serious hereditary diseases ;
- 2.2 that the practice be limited to specialized public or private centres subject to the same regulations ;
- 2.3 that donors be selected on the basis of medical criteria and a clinical interview during which they are made aware of the significance of the step they are taking ;
- 2.4 that the following standards be respected :
 - the written consent of the couple must be obtained ;
 - the donor is not remunerated ;
 - the sperm of one donor may not be used more than 10 times or after two births ;
- 2.5 that couples be informed about the techniques and medication used and about the true success rates (the number of women giving birth to a live child / the number of women inseminated during a cycle) ;
- 2.6 that any selection of sex for the sake of convenience be prohibited, unless there is a risk of transmitting serious sex-related hereditary diseases ;
- 2.7 that the necessary steps be taken to prevent the transmission of AIDS :
 - freezing of sperm ;
 - repetition of tests ;
- 2.8 that the conditions required to eliminate the anonymity of donors be respected in the case of artificial insemination with a donor, that the mixing of sperm be forbidden and that the required medical and non-medical data be collated ;
- 2.9 that the child, when he comes of age, be given access, upon request, to nominative medical and non-medical data and that the parents and the child when he turns 14 be given access to non-nominative medical data.

3. In vitro fertilization

Priority should be given to limiting this practice because it endangers women's health, its effects, including those of

hormonal stimulation, are still unknown and ethical problems are raised by the creation of supernumerary embryos.

The Conseil recommends :

- 3.1 that in vitro fertilization be considered a technique of last resort and be reserved for couples, the female partner of which has a demonstrated fertility problem and wishes to have a child as a partner in the couples, and that the donation of eggs be forbidden ;
- 3.2 that fertility clinics inform their clients about the techniques and medication used and their effects, the clinic's true success rates (the number of women giving birth to a live child / the number of women subjected to hormonal stimulation), and other data in the clinic's annual report ;
- 3.3 that fertility clinics collate the data to be provided in their annual reports, notably those concerning the techniques and medication used, the characteristics of their clientele (type of infertility, age and so on), success rates, the number of pregnancies brought to term, the number of multiple pregnancies, ectopic pregnancies, spontaneous abortions, selective abortions, births by Caesarian section, malformations, etc. ;
- 3.4 that in vitro fertilization be considered an experimental practice and that women therefore be given adequate information about it and that it be controlled and systematically monitored in order to evaluate :
 - the side effects of the medication used for hormonal stimulation ;
 - the physiological effects of the procedures required to remove eggs (laparoscopy, ultrasonography, etc.) ;
 - the effect on pregnancy of implanting embryos (multiple pregnancies, embryo reduction, ectopic pregnancies, miscarriages, etc.) and the effect on delivery of implanting embryos (Caesarian sections, birth of twins, etc.) ;
- 3.5 that the ministère de la Santé et des Services sociaux provide current data on hormonal stimulation and see that research is conducted on its short, medium and long-term effects, with a view to documenting the effects and informing the public and users about them ;
- 3.6 whereas the Conseil has strong reservations about hormonal stimulation and the implantation of several embryos, it recommends :
 - that the procedures be made more effective so that only one embryo is implanted, thereby eliminating recourse to hormonal stimulation ;
 - that, in the meantime, the procedure be limited to the fertilization of three eggs, resulting in the implantation of three embryos, so as to prevent the creation of supernumerary embryos ;

- 3.7 that an advisory body (created in accordance with recommendation 6.5) study matters related to the donation of gametes, the possibility of multiple births, embryo reduction and the disposal of supernumerary embryos now in some clinics.

4. Preconception contracts

Priority should be given to putting a stop to preconception contracts and curbing their commercialization.

- 4.1 that section 135.1 of the Youth Protection Act, which provides for sanctions for any person who attempts to derive benefit from placing or adopting a child, be amended to make it applicable to preconception contracts so as to prevent their commercialization ;
- 4.2 that the publication of advertisements for contracting mothers for preconception contracts be prohibited.

5. Prenatal diagnosis

Priority should be given to limiting the use of the various techniques because of their effects on women's health and the fetuses, and the dangers of eugenic selection.

The Conseil recommends :

- 5.1 that recourse to prenatal diagnostic techniques be limited to situations where they are medically required ; and
- in regard to ultrasonography :
 - that the written consent of the women be required ;
 - that studies be conducted on its effects on women and fetuses ;
 - in regard to amniocentesis :
 - that the women be told why the technique is being prescribed, its benefits and its dangers ;
 - that the written consent of the women be required ;
 - in regard to chorionic biopsy :
 - that the women be informed about the reasons for using the technique, its benefits and its dangers ;
 - that the written consent of the women be required ;
 - that women who have undergone the procedure be monitored to assess the reliability and quality of the results obtained, the number of spontaneous or induced abortions subsequent to the procedure and the grounds invoked for the voluntary interruption of pregnancy ;
- 5.2 that any recognized technique for sex selection through artificial reproduction and any research whose purpose or effect is to permit the sex of children to be selected before birth be prohibited ;
- 5.3 that broader consultation, not restricted to the scientific and medical community, be carried out regarding the devel-

opment and practice of prenatal diagnosis in Québec and that women be asked to contribute.

6. Priorities for research and services, and monitoring of practices

Practices should be carefully monitored, and services to prevent and treat infertility (see 1) should be promoted in order to limit services aimed at palliative measures.

The Conseil recommends :

- 6.1 that the ministère de la Santé et des Services Sociaux set up and ad hoc committee, mandated to set the criteria for accreditation of all specialized centres and to define the mechanisms for the evaluation, monitoring and control of the conditions in which the new human reproductive technologies are used, e.g. criteria for the selection of clients and techniques used ; this multidisciplinary committee would be composed of representatives from the social sciences and humanities, representatives of the legal profession, feminist researchers and disinterested representatives of the medical profession ;
- 6.2 that the use of artificial procreation techniques be restricted to duly recognized and accredited centres ; that the number of such centres be limited and priority be given to the treatment of infertility ; that the present number of centres (5) practising in vitro fertilization not be exceeded and that they abide by the requirements in regard to experimental techniques (see 3.4) and the limit on the number of embryos (see 3.6) ;
- 6.3 that the status quo be maintained in regard to the funding of fertility services and related medical acts ;
- 6.4 that there be a moratorium on embryo research ; that a systematic inventory be made of research under way and that this matter be submitted to the advisory body whose creation the Conseil recommends ;
- 6.5 that the Québec government create an advisory body on moral issues in particular with a mandate to advise on major issues related to reproductive engineering and the qualitative management of births, to evaluate new reproductive practices and research and to inform the largest possible public ; its mandate would also cover broader life-and-death issues (such as eugenics, genetic manipulations, euthanasia and the donation of organs) ; it would be composed of representatives of society who are highly credible and well informed about the ethical, social and legal issues raised by the scientific developments. Women should be well represented ;
- 6.6 that the ministère de la Justice study the relevance of adopting a general law on new reproductive technologies, inspired by the experiences and legislation of other countries.

Publications of the Conseil du statut de la femme Dealing with New Reproductive Technologies, 1985-1988

Research reports (available only in French)

1. *Nouvelles technologies de la reproduction: Questions soulevées dans la littérature générale*, Fernande Rousseau, Pierre R. Desrosier, Québec, September 1985, 78 pp.
Overview of the new reproductive technologies, their applications and the issues they raise. (285-09-R)
2. *Nouvelles technologies de la reproduction: Pratiques cliniques et expérimentales au Québec*, André Jean, Québec, January 1986, 98 p.
Description of reproductive engineering research and practices in Québec. (286-01-R)
3. *Nouvelles technologies de la reproduction: Analyses et questionnements féministes*, Lise Dunnigan, Louise Barnard, Québec, March 1986, 161 pp.
Summary of feminist views on the new human reproductive technologies. (286-03-R.2)
4. *Nouvelles technologies de la reproduction: Études des principales législations et recommandations*, Marie Choquette, Québec, March 1986, 94 pp.
Survey of the legislation in force in various countries respecting the new human reproductive technologies. (286-03-R.1)
5. *Portrait statistique des couples qui ont recours à l'assistance médicale pour résoudre un problème d'infertilité*, Céline Peron, Québec, April 1986, 55 pp.
Quantitative study of the use of fertility services in Québec's health establishments. (286-01-R.2)
6. *Les enfants que je veux... si je peux...*, Françoise-Romaine Ouellette, Québec, January 1987, 184 pp.
Qualitative study of 32 infertile women receiving medical assistance to become pregnant. (287-01-R)
7. *Le diagnostic prénatal: Recherche et recommandations*, Lise Dunnigan, Hélène Valentini, Québec, April 1987, 145 pp.
Analysis of prenatal diagnostic techniques used in Québec, their effects on the health of women and fetuses, their psychological and social impact and recommendations to limit their use. (287-08-A)

These reports may be obtained free of charge upon request from:

Conseil du statut de la femme
8, rue Cook, bureau 300
3^e étage
Québec (Québec)
G1R 5J7

Background papers

1. *Dilemmas - When technology transforms motherhood*, Francine Gagnon, CSF, Québec, 1987, 40 pp. (\$3.95)
A lively, easy-to-understand discussion of the above research reports. The publication gives a general description of artificial reproductive methods, prenatal diagnosis and practices in Québec, reviews the moral, ethical and legal issues they raise, relates the experiences of infertile women and provides a feminist analysis of the subject.
French version entitled *Enjeux - Quand la technologie transforme la maternité*.
2. *Sortir la maternité du laboratoire*, Québec, 1988, 423 pp.
The full texts of the 40 papers (some in French and some in English) delivered by the international experts who participated in the Forum on New Reproductive Technologies, organized by the Conseil du statut de la femme and held in Montréal in October 1987, as well as summaries of the discussions that took place in the eight workshops and during the opening and closing meetings.

The background papers may be ordered from:
Les Publications du Québec
Case postale 1005
Québec (Québec)
G1K 7B5
(418) 643-5150
1-800-463-2100 toll free

Audiovisual productions

1. *In the pale womb light*, a 52-minute video produced jointly by the Conseil du statut de la femme and the ministère des Communications, available in U-Matic, BETA and VHS formats, 1987. French version entitled *Au clair de l'ovule*.
Produced to increase awareness about the new reproductive technologies, the video is an analysis from a female perspective of in vitro fertilization, artificial insemination with a donor, surrogate motherhood and the issues raised by these technologies, including the anonymity of sperm donors, the validity of preconception contracts, the status of embryos, sperm banks, egg banks, genetic manipulations and eugenic possibilities.

2. *NKT Alert*, a 57-minute video produced jointly by the Conseil du statut de la femme and the ministère des Communications, available in U-Matic, BETA and VHS formats, 1988. French version entitled *Alerte à la procréatique*.

Providing the highlights of the International Forum on New Reproductive Technologies organized by the Conseil du statut de la femme, the video deals with experimentation on women's bodies and the real interests of researchers in this field. Exclusive interviews with the international experts who participated in the Forum.

3. *La procréatique en question*, a series of 12 videos, of which 3 are in English and the remainder in French, produced jointly by the Conseil du statut de la femme and the ministère des Communications, available in U-Matic, BETA and VHS formats, 1988.

Exclusive interviews with figures in the health, legal and education fields from Québec, Switzerland, England, Australia and the United States about reproductive engineering.

These audiovisual productions may be obtained from:

RENTAL

VIDÉOTHÈQUE
Service de la diffusion
audiovisuelle
Ministère des Communications
Édifice Cyrille-Duquet
1500-D, boul. Charest O., RC
Sainte-Foy (Québec)
G1N 2E5
(418) 643-5169

SALE

LES PUBLICATIONS DU QUÉBEC
Case postale 1005
Québec (Québec)
G1K 7B5
(418) 643-5150
1-800-463-2100 toll free

Conseil opinions (available only in French)

1. *Le diagnostic prénatal: Recherche et recommandations*, Lise Dunnigan, Hélène Valentini, Québec, April 1987, 145 pp.
Research and recommendations regarding prenatal diagnosis.
2. *Mémoire portant sur le droit de connaître leurs origines pour les enfants adoptés ou conçus au moyen d'une technique de procréation assistée*, Marie Rinfret, Jocelyne Olivier, Francine Gagnon, Québec, May 1987, 25 pp.
Brief dealing with the right of adopted or artificially conceived children to know their origins.
3. *Les grossesses sous contrat*, Marie Rinfret, Québec, June 1987, 6 pp.
An opinion submitted to the Minister for the Status of Women, dealing with preconception contracts.
4. *Opinion-synthèse*, Francine C. McKenzie, Québec, April 18, 1988, 3 pp.
An opinion prepared by the former President of the Conseil du statut de la femme and submitted in conjunction with the report by the interdepartmental task force on the new reproductive technologies.

These opinions may be obtained free of charge from:

Conseil du statut de la femme
8, rue Cook, bureau 300
3^e étage
Québec, (Québec)
G1R 5J7

...dans le cadre de la loi sur l'accès à l'information.

Principes de la Loi sur l'accès à l'information

La Loi sur l'accès à l'information a été adoptée en 1982. Elle vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

La Loi sur l'accès à l'information est une loi fédérale qui vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

La Loi sur l'accès à l'information est une loi fédérale qui vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

La Loi sur l'accès à l'information est une loi fédérale qui vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

...dans le cadre de la loi sur l'accès à l'information.

Principes de la Loi sur l'accès à l'information

La Loi sur l'accès à l'information a été adoptée en 1982. Elle vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

La Loi sur l'accès à l'information est une loi fédérale qui vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

La Loi sur l'accès à l'information est une loi fédérale qui vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.

La Loi sur l'accès à l'information est une loi fédérale qui vise à garantir le droit de tout citoyen d'accéder à l'information détenue par le gouvernement fédéral.

Les principes de la Loi sont :

- 1. L'accès à l'information est un droit fondamental.
- 2. L'information doit être accessible à tous.
- 3. L'information doit être divulguée dans un format accessible.